Health Development in Bangladesh

by Dr. Khalilur Rahman

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EALTH development is closely associated with L the overall development process of any nation. Centrality of health in all development processes has been recognised by all. Role of health in development was also recognised by the UN.

The UN General Assembly adopted a resolution (No. 34/58) wherein it termed "health as an integral part of development". The Health For All (HFA) movement launched by the 30th World Health Assembly, considered health a basic human right and a worldwide social goal. The Alma-Ata Declaration of 1978 at the conclusion of an International Conference on Primary Health Care (PHC) stated that primary health care was the key to attaining the target of HFA as part of development in the spirit of social jus-

Bangladesh became member of the WHO in 1972, even before her membership to the UN. Since her joining this world body for health, she has been trying to improve the health status of her population. WHO has been a useful partner in her efforts to this direction. Alike other member-states of the WHO, Bangladesh also began to implement the HFA Strategy soon after its inception in 1979. In the implementation process of the strategy, she has been facing tremendous difficulties mainly from a cycle comprising poverty, population growth and environmental degradation (PPE). A fourth factor — illiteracy, is greatly contributing to making this cycle a "vicious"

The development efforts in Bangladesh have been undermined by the incidences of poverty, population growth and environmental degradation. These elements are closely interlinked and their adverse impacts on health are notorious. It is more visible in Bangladesh because, the country faces an extremely difficult demographic situation — a population of 125 million in a total area of 143, 998 sq. km.

Poverty in Bangladesh stems mainly from over population and its high growth rate and inequity in access by the poor to the meagre resources. The large population, on the other hand, has been causing overuse of forests, fisheries and land resulting in environmental degradation. Moreover, in order for meeting the needs of this large population, increased economic activities are being undertaken without taking due account of environmental preservation aspect.

The end result of all this is that the health of the entire population is being affected. The process is also leading to economic insecurity resulting in high birth rate. Thus the cycle is revolving.

Increase in literacy rate and in primary school enrolment has been found to be strongly associated with more rapid increases in per capita incomes and with greater economic equality. The education status of the people in Bangladesh is low, particularly among young girls, women and the poor. The low education status of the people aggravates the problems of poverty and population growth in Bangladesh. Illiteracy, commonly found among the women and the poor, continues to impede health and social development through its nefarious effects in a number of ways in the country.

Low status of education among women has contributed to their low status in all walks of life in the society. Their empowerment, right to reproductive health and gender inequity is greatly affected by their low education status. Investing in women's capabilities and empowering them to exercise their choices is not only valuable in itself but also the surest way to

A CONCEPTUAL SYSTEMIC MODEL FOR THE STRATEGY FOR HFA Reorganization & Decentralization Increased Budgetary Allocation in of Health Services Health & Social Sectors Poverty Alleviation Women's Development Education Population Control HFA. improved Health Status Improved Health Status STRATEGY Education, Population •Increased & Effective Control, Poverty Alleviation, Collaborative Role of WHO Women's Development, *Increased Flow of External Conservation of Environment fund to Health Sector Political Commitment Population Control Poverty Alleviation Increased NGOs Social Mobilization Women's Development Involvement in Social Community Participation in Health & Social Issues Conservation of Environment Overall Social

contribute to economic growth and overall development of any

WHO, in collaboration with the World Bank, documented the importance of investing in health and identified that interventions to promote women's health as being the most cost-effective. The improved education status of the people may protect them from exploitation of all sorts and bring them financial solvency. An educated man by all means can certainly improve his health status compared to an illiterate Despite relentless efforts by

the successive Governments, the health system in Bangladesh could not still provide minimum health care services to the population. The worst sufferers are of course, the poorer section of the population. A number of health subsectors need to be improved a lot, which, among other things, include increase in public expenditure in health and efforts for alternative financing for health care, making available of drugs, logistics etc., development of human resources. strengthening of managerial, coordinating and monitoring system, re-organisation and decentralisation of health system, separation of health from family planning, ensuring equity in health care delivery and necessary reforms including introduction of a national health policy, prohibition of private practice by the Government doctors, appointment of health professionals at the Ministry of Health and Family Welfare etc.

Bangladesh is virtually caught in a "vicious cycle" of poverty, population growth, environmental degradation and illiteracy. This cycle needs to be broken not only for the improved health status of the population; but also for the overall development of the entire country. Poverty, among these four ingredients of the cycle, is the root-cause of ill health and diseases in Bangladesh. Given the nefarious effects of poverty on health, efforts should be made for poverty alleviation with special emphasis on women and children. Substantial progress should be made in education, employment generation, nutrition and family planning with a view to reducing negative impacts of this cycle on the soci-

The most important problem in Bangladesh is perhaps our large population. While we blame on poverty as the rootcause of the ill-health and diseases, large population is mostly responsible for poverty situation in the country. If we can contain the population growth rate, many problems can easily be tackled and we can

make our country a prosperous one. There is an urgent need to raise the educational level of the entire population. An educated society can significantly contribute to formation of a better and prosperous society by reducing population growth and

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improving poverty situation. Education, in particular to women, could reduce population growth rate and provide better health care and nutrition. Given the low education status among women and girls, special provisions should be made for their education. We need to ensure primary education for all at the shortest possible time. In order to do so, centrality of primary education should be recognised and the same be placed at the top of the national list of priority.

Environmental degradation is closely related to poverty, education level and population growth. Unless poverty is reasonably alleviated, population growth rate is contained and literacy rate is raised, environment cannot be preserved and improvement in health sector cannot be ensured and progress achieved so far in health sector, cannot be sus-

NGOs in Bangladesh have been involved in social development. The success of some NGOs in our country has been widely acclaimed both home and abroad. In some areas, their contribution is significant and exemplary. Many of their programmes have been replicated in many countries of the world. With further streamlining of their activities, much progress can easily be achieved in all areas of social progression including the health development. Time has come to get them as real development partners; not to view them as alternative force of social development. They can significantly supplement the efforts of the Government. A vrai partnership needs to be forged with NGOs and private sector for the health development in our

Limited resource is another important obstacle to health development in Bangladesh. An LDC like her depends much on external financing for her development efforts. While we do need external assistance for our development projects, at the same time we need to look back to our own resources. Efficient financial management has now become an important responsibility of all governments. The more one is efficient in financial management, the better he can perform. We need to efficiently use our limited resources. Prioritisation of development projects is a must for optimal utilisation of our meagre resources. Reallocation and substantial increase in financial resources are urgently required for the improvement of health sector.

Moreover, the Government needs to initiate measures for alternative financing for health care services. This could be done by introducing social insurance schemes, health tax on the well-off section of the population, setting up of national health fund etc.

Predictable and sustained external financing is to be ensured for our overall development. We need to remind the donors and the international community about their commitments made in various international conferences for providing assistance to the poorest countries and to ask them to translate their pledges into action. As the leader of the LDCs, our Prime Minister has been reminding the G-8 leaders prior to their every Annual Meeting that the poorest countries like ours need their increased support, in particular, in respect of predictable and sustained assistance for their development efforts. She has been duly performing her responsibility. The bureaucracy now needs to get its work together and initiate follow up action to her initiative, in all relevant international fora.

As stated earlier, health development is an integral part of overall development efforts. Back home, a number of UN bodies and international agencies are working in various areas in support of the Government efforts in progressing overall social development of the country. Health development should not be separated and isolated from the holistic approach to development. The Government needs to coordinate the development works of various organisations so that duplication of works and efforts could be avoided and resources therefrom could be utilised in other priority devel-

opment purposes. WHO's HFA Strategy is a coordinated programme for health development. Government is also aware of this fact. What is needed now is to implement this strategy. I undertook a Ph.D study on the implementation of the HFA Strategy in Bangladesh. I found in my study that a number of actors had both direct and indirect impacts on the health sector. Based on the findings of the study, following Systemic Model was developed. This model can perhaps provide some guidelines to the policy makers in the Government for undertaking necessary reforms in our health sector.

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Will Equity in Health Work?

by Dr M Zakir Husain

All civilised societies acknowledge health as a basic human right just as education is. Just as to deny education is a sin so is the act of depriving anyone of access to health care for whatever reason. Health is as basic as the right to life, Yet, health inequities persist and even get worse between countries and within countries.

OCIAL inequities are as old as human societies. I would like to propose that equity in health is not only achievable and largely non-controversial, but also may help reduce other forms of social inequities. It would also be naive to assume that even health inequity can be totally eliminated while other inequities are left to per-

But wherefore the idea of removal of health inequity arise? First, all civilised societies acknowledge health as a basic human right just as education is. Just as to deny education is a sin so is the act of depriving anyone of access to health care for whatever reason. Health is as basic as the right to life, Yet, health inequities persist and even get worse between countries and within countries. Ironically too, those who need health care more are also usually those who have it least.

The very word equity means different things to various schools of thought. But suffice it to say that it means, at the least for the present discussion, equal access to essential health care irrespective of anything to the contrary. It does not mean all will enjoy equal state of health or that health resources will be equally distributed to all. But certainly it will mean shift of available resources for health care to areas and people where and whose needs are greater; it will mean less to the already privileged and more to the under-privileged, the vul-

nerable, the weak and the poor. No doubt, there will be resistance to such a shift from those who are used to more, but the writer would believe the resistance will be less than what will be for shift of income directly to the poor from the rich. Taxation of the rich to make direct transfer to the poor will be less tolerated than mere making more health care available to those who need it more.

We know there are existing inequalities of access to, or possession of, resources or other means of production; there are subtle and harsh forms of class inequality; free market allows more to flow to where there is

already more. The affluent consume many times more than the poor and needy. But does that necessarily get the rich more health security? I believe not or at best only a temporary

and uncertain sense of security. Disease agents travel without any regulation; need no visa to cross country borders nor to cross class boundaries. If for no other reason, there is enough to support equity in health care by the society for the security of all and enlightened self-interest of

its affluent class. Now, if there is merit and more than moral reason in health equity, how to bring it about? First, let us get clear of academic or semantic controversy about the meaning of equity. We can settle for a simple easy to apply meaning. To re-peat, for the present discussion, equity in health means equal and unrestricted access to health care by all and not by a few as at present.

Now, we are under a regime of market economy and structural adjustment. The state is being "downsized", some are saying it actually is "right-sizing". Whatever it is, the state is withdrawing from public financing of health; the private market is getting prominent. But by definition the private market must maximise profit. Health private market is no exception as is already well shown. Total national health expenditure is rising, and rising rapidly. But its distribution is tilted more towards those who can afford to pay and they are indeed paying more. Those who cannot are left out of the market or are made to pay by selling their assets in emergency ill-

Is it equitable? No it is not.

Whatever else, private health care market is notoriously inequitable. But then what can be done? The public sector in health is already poorly financed; it will be even more starved of funds with time as costs go up and budgets come under scrutiny. It will be asked to raise its own funds to supplement its budget and fill the

But that will compel the

public sector to start collecting charges which the very poor will not be able to pay. Those who can pay may not do so for services they feel are irregular and of low quality or inconvenient. But this writer would argue the situation need not be as sceptical or grim as it appears

First, there is no need for the government or voluntary nonprofit agencies to withdraw from the market. There is need for them to select priorities and make meaningful and transparent partnership with the clients and among themselves. There is need to put more resources into primary care specially at the remote and peripheral health facilities that are closest to the population in need (for rural as well as urban poor) yet are ironically the most neglected or under equipped and under financed.

There is need to resuscitate public health environment and sanitation programmes and related services especially to the most needy population. There is every need to put more money and management into local health organisations with informed and institutionalised people's participation. And there is every reason to shift resources preferentially to essential public health functions that serve and protect the population as a whole.

Is it any surprise that the corollary of doing all these will be intelligent and courageous reallocation of resources; more for services that protect equity and less for services that work against equity - for example away from expensive tertiary care for the few that gives low net health outcomes. The writer is under no illusion these are very hard and unlikely choices not easily made or implemented. But then can the society and the government of the people do anything less? Can the profession or the

custodians of liberal society condone and congratulate the perpetuation of existing inequities? Rather than engage in leisurely and sterile academic debate on the definition and description of social inequities, is it not time to do something in

practice and begin to learn lessons that are to be learnt?

As stated before, I am aware of the fact that with persisting inequities in income, assets and access to other means of production, education, shelter compounded by class and cultural barriers, there is no health "utopia" in sight anywhere or anytime soon, if ever. Take for example education. Do you the reader honestly believe that by mere lofty intentions or by allocation of more money to "education" sector of the fiveyear plan we will achieve full literacy? Do we not have enough evidence that without a revolutionary commitment, all allocations have a way of being absorbed by a lethargic bureau-

cracy (red Parkinson's Law)? Even a Kemalist revolution may fall a little short of what is needed to attain full literacy in early next century. This writer does not belittle the need for financial investments but wishes to suggest that without full and bold commitment by the state and the society and without he "sacrifices" of the affluent and the privileged — willing or enforced - social goals as fundamental as equity will remain distant.

Yet, it seems that the reduction of health inequities may indeed be a less difficult task. The infrastructure is there, the means and methods are affordable and available, less commotion and clash of interest is at stake, and a responsible private and non-profit voluntary sector may even lend a helping hand. Hopefully this can happen. And when there is equity in health it may generate enough evidence of a success story to inspire, who knows. perhaps a thirst for other success stories say in education.

The creative energy released by health equity may well create the confidence needed to go through few other difficult reformation processes in the society as a whole. For let us all hope that a healthy population with creative energy and selfconfidence is the most precious asset and a powerful engine for change of the society.

India's Male Sex Workers Come out of the Shadows

Ranjita Biswas writes from Calcutta

In Indian society, male prostitutes live in a shadowy world and the subject is never mentioned in genteel circles. Yet, according to a report by the Panos Institute of London, there are 50,000 male prostitutes in the western metropolis of Mumbai alone.

UNIL Das, who once lived on other people's Verandahs, could not have imagined in his wildest dreams that he would one day visit picturesque Switzerland.

But Das did, this summer. A male prostitute from the east ern Indian metropolis of Calcutta, the dark and diminutive Das, his eyes lined with kohl, was in Geneva to participate in the 12th World AIDS Conference which was attended by an estimated 13,000 international delegates. More than the Swiss visit, the high point in Das' life and that of compatriot Sonu was that their presence had been acknowledged, the fact finally noted that male sex workers in India existed and had

their own problems. In Indian society, male prostitutes live in a shadowy world and the subject is never mentioned in genteel circles. Yet, according to a report by the Panos Institute of London, there are 50,000 male prostitutes in the western metropolis of Mumbai alone. No official figures were immediately available for Calcutta, but according to rough estimates they are in thousands in this city

Das and Sonu went as part of a delegation that mostly

from Sonagachi, the largest red light area in Calcutta. Komal Gandhar, a cultural group from the area named after a note in Indian classical music, presented a dance drama at the inauguration ceremony of the conference.

comprised women sex workers

Komal Gandhar is part of the Durbar Mahila Samanwya Committee (DMSC), an empowerment organisation comprising Sonagachi workers -- which

so far had only targeted women. The DMSC has conducted an HIV/STD intervention programme initiated by the All India Institute of Public Health and Hygiene and workshops on law governing their profession and demand for legalisation of their trade.

Though the Sonagachi programme is seen as a model for project planners in intervention programmes among sex workers, no one noticed one omission: male prostitutes. The DMSC members themselves were taken aback when male sex workers approached them for membership.

The brainstorming in the many subsequent meetings convinced DMSC members that male sex workers had their problems too. Moreover, they were no different from their

larger social context: exploitation, confinement to the fringes of society, sense of personal loss and alleged harassment by the police. "In fact, our case is worse. At

female counterparts in the

least the society accepts, though covertly, that there are women in the sex trade," laments Madhu Sarkar, the 28-year-old leader of the group who also happens to work in the film industry and is a dancer.

"And the women at least have a place to stay. We can't call anyone home. We have to visit clients at their home and often there are incidents of untold physical abuse," Sarkar

Das is now a peer worker and like women peer workers helps in popularising the use of condoms. Sarkar, however, claims that male sex workers always practise safe sex and condom use is the norm rather than the exception among

Talking about people of his ilk, Das says softly: "We are human beings too and care for our families. I look after my widowed mother. She has now accepted my profession. At least the days of starvation and shifting from one verandah to another with landlords treating you like dogs are over. I have even bought a TV set and my mother can enjoy her free time watching it." Lambasting society for its

hypocritical standards, Sarkar says that among their clients were doctors, engineers, professors, businessman, many of them householders with children. The feeling of insecurity among male sex workers is high, he says, because "when we get picked up from a restaurant or from near a cinema hall near Chowringhee (downtown Calcutta's business district) we really don't know how the client will behave in the isolation of

He tells harrowing tales of inexperienced male prostitutes being abused and thrown out of the house by the client without being paid. Another problem is the constant police harassment, "though many in the force are our clients".

his premises."

Yet, Sarkar finds it heartening that, thanks to the DMSC, they have now "come out of the shadows". Future plans include establishing an interactive centre where others can drop in and discuss their problems and expert help could be sought on health issues.

-India Abroad News Service

Drink of Death?

ILLIONS of cans of fizzy drinks and bottles of sparkling water have been withdrawn from sale in the UK because ■ V ■ of fears that they could contain traces of the cancercausing chemical benzene.

The company, Cadbury Schweppes has withdrawn its bottled Malvern sparkling water following reports that the water contained benzene levels of 10-20 parts per billion (PPB). Other well-known brands including Lilt, Coca-Cola, Fanta and Sprite have also been withdrawn from the market.

The World Health Organisation has recommended safety limit for benzene as 10 PPB. SmithKline Beecham, the manufacturer of the brands Lucozade and Ribena, is testing its products. It will await the results before deciding the future action

Rob Hayward, chief executive of the British Soft Drinks Association said that the benzene originated as a contaminant in earbon dioxide manufactured by Terra Nitrogen, a UK-based company, which supplies a majority of the soft drinks in

Asharp decline in numbers or possible extinction, says the Worldwatch Institute, Washington, USA. "We are in the midst of

brates - mammals, fish, amphibians and reptiles - faces

Disappearing Act N estimated one of every four species of the world's verteauthor of the study.

The main reason for vertebrates decline is the destruction of old growth forests, wetlands, dense tangled underbrush and other rich habitants, including aquatic ecosystems. The report also blames over-hunting and over-fishing of the world's stocks of animals and fish for the present crisis.

mass extinction, an event not seen since the disappearance of the dinosaurs 65 million years ago," says John Tuxill, the

A 1996 study conducted by the World Conservation Union had found that 25 per cent of mammal and amphibian species. 11 per cent of birds, 20 per cent of reptiles and 34 per cent of the fish species, which were surveyed, were facing extinction. In addition, five per cent to 14 per cent of the species in these groups were "nearing threatened status".

Compressed to Cool

LTHOUGH CFCs and related chemical are being phased out as they damage the ozone layer, it has been difficult to find a replacement for them in car air conditioning. Daimler-Benz, Germany's automobile giant, is now testing an air conditioner that uses compressed carbon dioxide instead The gas was used in the earlier refrigerators, but abandoned since it needs very high pressure. However, with modern materials, this is no longer a problem.

CSE/Down To Earth Features

Assam Town Reports Bizarre 'Telephone Death'

ITTLE did 25-year-old Jayaprakash know when he advanced towards the ringing phone to lift the receiver that it would be the last time he was doing it. A moment after he picked up

the receiver, Jayaprakash, who had just walked into his home at noon for his lunch, dropped dead. He was reportedly electrocuted, a newspaper has said.

Apparently, Jayaprakash's was not the only such bizarre case in his neighbourhood of Gohpur in Tezpur, a town in the northeastern Indian state of Assam. About the same time, people in other homes in the neighbourhood who had lifted their ringing phones were injured, apparently because of the high voltage current passing through the instruments. The

Indian Express reported. The Assam Police and officials of the state telecom department, alarmed by the curious incidents which occurred late last month, are trying to probe the matter.

However, telecom officials

have been postponing investigations as tempers are running high in the Gohpur area, the paper said. "People are very angry and we are scared to go (there). We can make investigations only when we get police escort.' they were quoted as saying.

Mahendra Kumar Aggarwala, who reportedly sustained 40 per cent burns after he received a shock from the telephone receiver, told the paper: That day (July 25), the telecom staff were working on some ca-

ble fault when the electric wire (overhead high-tension line) carrying 11,000 kilo volt of current snapped and touched the main telephone line. All telephones in the area started ringing and whoever picked up the receiver was injured."

The overhead wire was finally removed by one of the telecom department employees with the help of a bamboo pole, Aggarwala added.

However, the Chief General

Manager of the state telecom authority, who was not named by the paper, denied that Jayaprakash had died of electric shock from his telephone instrument. "There could be a local fault which could have given a mild shock but nobody has died from current flowing through them (telephone

lines)," he said. "For a person to die of electrocution, a current measuring at least 150-200 volts is required to pass through the heart," the Chief General Manager said, "while telephone wires can carry a maximum of

50 volts.

"Telephone instruments cannot survive such heavy current. If there is a strong current, the equipment at the exchange will catch fire and melt first, the manager was quoted as say-

"Also there is no question of all 162 telephones in the area ringing simultaneously because a rack contains only eight to 16 lines and only those will ring." he added.

-India Abroad News Service









